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RESEARCH REPORT (K201501)

Formulating foster care in Scotland for young children's emotional and mental wellbeing



This report summarises the findings of original research carried out by the University of Edinburgh/NSPCC Child Protection Research Centre into the way in which foster carers may support the mental health needs of children in their care.

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February, 2015

Author contributions: JT and LM conceived and designed the study. CS and KS carried out data collection and initial analysis. Further interpretation and analysis undertaken by JT and CJ. CJ and CS drafted the initial reports. KM conducted further data analysis and literature reviewing to prepare this final report. JT participated in all aspects of the study as supervisor. All authors read and approved the final manuscript.

Additional contributions: Anna Anderson provided administrative, technical and material support. Louise Bazalgette was the key liaison with the Looked After Children Team at NSPCC. The study advisory group provided important context and feedback.

Study Advisory Group: Louise Bazalgette (NSPCC); Ann Black (TFN); Liz Brabender (CELCIS); Graham Bryce (GIFT); Maureen Hearn (N Ayrshire Council); Gillian Henderson (SCRA); Barbara Hudson (BAAF); Sara Lurie (TFN).

The Child Protection Research Centre works to help improve the recognition, response and prevention of child maltreatment through independent research, academic leadership and education. Positioned within the University of Edinburgh and in partnership with the NSPCC, our multi-disciplinary team is able to bring a broad, international frame of reference to help address entrenched and emerging issues in child protection. Our work is designed to strengthen advocacy, policy and practice in the UK and beyond so that children and young people are safe and survivors of abuse have access to the best care.

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Executive Summary

Introduction

Foster carers can play a key role in supporting a child's recovery from abuse and neglect and improving their mental health, but optimising this requires appropriate formulation of the care arrangements. This is a report on a scoping study into the extent to which the way foster care is conceived and supported, provides the basis for meeting the emotional and mental health needs of young children. It focuses on children aged up to 60 months who have been removed from their parents' care because of maltreatment, or risk of maltreatment and who have been placed in state provided (non-familial) foster care provision in Scotland.

The project had three main objectives:

- To establish what is known about the emotional and mental health needs of young children (aged zero to five years) coming into the care system.
- To look at the preparation and support for foster carers in Scotland relevant to caring for these children, through analysis of local authority documents.
- To explore the experience of foster carers in meeting the emotional and mental health needs of children, through interviews with a sample of foster carers.

Methods

The research was conducted in three phases:

Phase I Comprised two literature searches to identify what is known about the support for the emotional and mental health needs of the target group of children and the landscape of foster care in Scotland.

Phase II Identified the support given to foster carers for meeting the emotional and mental health needs of young children through analysis of documents from local authorities, augmented by interviews with managers from two local authorities.

Phase III Interviewed foster carers to gain their perspective.

Summary of key findings

Mental health needs of looked after children

- Increasing numbers of children under the age of 60 months are becoming 'looked after', while increasing numbers of all looked after children are being placed in foster care.
- Children within the care system are more likely to have poor emotional mental wellbeing than children in the general population. However, estimates of the prevalence of emotional and mental health issues vary depending on how broadly this is defined, how it is measured, how many different measurements are used and how the study population is accessed.
- Types of difficulties include behavioural and emotional issues due to exposure to various forms of maltreatment.
- There is very limited research on the prevalence of emotional and mental health issues in looked after children under the age of 60 months specifically. Estimates range from 19% (Sempik et al 2008) to 67% (Hardy et al 2013).
- Measurements of problems rely on caregiver reports (in some instances the parent), who may not recognise the child's behaviour as indicative of mental health need. Their assessments may also vary according to their confidence levels.

Formulation of foster care

- Local authorities strive to achieve permanence (a secure placement) for the child within tight time frames.
- Concurrency planning is permitted by the relevant regulations, whereby a child may be placed with a foster carer who is dual registered as both a foster carer and an approved adopter. This option may enable an infant to be adopted by their foster carer if reintegration with the birth family is not possible. The local authorities who took part in the study appeared to make very limited use of this option.
- There is evidence that local authorities support foster carers to address the mental health needs of infants in their care, through provision of ongoing training, through efforts to match the child to the carer, through the provision of information on the background of the child and through access to professional supports.
- Foster carers are able to describe a range of troubling behaviours from infants for whom they have cared. They value training and access to advice concerning behavioural issues.
- Foster carers help children to recover from abuse and neglect through the modelling of positive behaviour, efforts to build an attachment and efforts to stimulate the child's development.
- Foster carers have an important role to play in supporting contact between a child and the birth parent, as well as recording information that may inform decisions around permanence. They express a wish to be included in discussions around the future care of a child and for their opinions to be respected.
- Measures that promote attachment within the care system and improving the processes by which permanence is achieved are crucial.

Implications for future research

- Further research into how the concurrency model may be effectively carried out in practice is needed.
- The collation of data on effective add-on interventions in Scotland, which support foster carers manage the effects of abuse and neglect, could inform future policy and practice.
- Further research into the effectiveness of initial health screening given to children who become looked after is indicated. This should review the screening measures used following the identification of an unmet mental health need, their reliability, and interventions offered.
- Factors impacting on the uptake of the treatment should also be reviewed.

1. Background to the study

The policy vision in Scotland for looked after children includes the provision of services to enable looked after children to overcome the difficulties resulting from trauma, neglect or poor early care (COSLA, Fostering Network, BAAF, Scottish Government, 2008).

This is a report on a scoping study into the extent to which the way foster care as conceived and supported provides the basis for meeting the mental health and emotional welfare of young children. It focuses on children aged up to 60 months who have been removed from their parents' care because of maltreatment, or risk of maltreatment and who have been placed in state provided (non-familial) foster care provision in Scotland.

This report focuses on the day-to-day care provided by foster carers towards children looked after by them, rather than seeking to inform decision making in respect of when to take a child into care, or decisions over whether it is appropriate to return a child to their birth parent/s or not.

This report does not review add-on specialist interventions. The NSPCC commissioned report *What works in preventing and treating poor mental health in looked after children?*, which mostly focused on care in England (Luke et al 2014), included a review of some intensive add-on interventions which help support the mental health needs of children in foster care.¹

This report outlines current practices in Scotland which support the mental health needs of children in the care system through a review of local authority documents and interviews with foster carers and local authority managers. Current practices include the mandatory assessment of the health of children as they enter the care system, the training and support offered to foster carers by local area authorities and efforts to secure a permanent placement for the child within a short time frame. Findings from interviews with foster carers reveal a variety of different ways in which the 'ordinary care' foster carers give to children may effect changes in the demeanour and responsiveness of very young children.

Section eight of this report focuses on 'concurrency planning' for very young children coming into the care system – whereby they may be placed with foster carers who may adopt the child should attempts to rehabilitate the child to their family of origin fail. This process has the potential to enable a child to develop a secure attachment to a consistent carer and may avoid the disruptive and potentially long term impact of placement disruption. However, among the local authorities taking part in this research, there was evidence of a reticence to embrace concurrency planning.

¹ This is available at: <http://reescentre.education.ox.ac.uk/wordpress/wpcontent/uploads/2014/09/onlinePoorMentalHealthfullreport.pdf> and mostly focuses on care in England (although the literature reviewed is international). These authors' found no interventions designed to target behavioural difficulties for this age group that involved direct work with children under the age of 60 months (pg 82). However they review four interventions providing different levels of support to foster carers (pgs 82-85).

2. Outline of project

The aim of the project was to scope the ways in which the foster care system may provide the basis for meeting the mental health and emotional needs of infants.

The project comprised three main objectives:

Phase I: To establish what is known about the emotional and mental health needs of young children (aged zero-five years) coming into the care system.

Phase II: To look at the preparation and support for foster carers in Scotland relevant to caring for these children through analysis of local authority documents.

Phase III: To explore the experience of foster carers in meeting the emotional and mental health needs of children through interviews with a sample of foster carers.

3. Methods

3.1 Phase I – Literature Review

In phase one a systematic search for literature on the mental health needs of looked after children was undertaken.² We also drew on a literature review undertaken for the NSPCC, London, in 2014 entitled *Achieving emotional wellbeing for looked after children* (Sweet; unpublished).³ Together, these materials formed the basis of the findings presented in Part 6 of this report. An additional review of the Adoption and Children (Scotland) Act 2007, the Looked After Children (Scotland) Regulations 2009 and the Guidance to the Looked After Children (Scotland) Regulations 2009 was also undertaken to inform Part 7 of the report.

3.2 Phase II – Local Authority Documents

Sixteen (50% of all) local authorities in Scotland were contacted with a request to send copies of documentation used in their local authority, which had relevance to foster care provision. Suggested documents included those covering: foster care policies, procedures and guidance; foster care recruitment strategy and information packs; foster carer training and support policies; policies on permanency, concurrency, matching and placement and on fostering panels.

A quasi-random sample of local authorities was obtained by ranking all authorities according to the Scottish Index of Multiple Deprivation (SIMD), whether these were urban or rural, and then selecting every second local authority. Nine local authorities returned at least some documentation.⁴ This

² Smith searched the following databases: SCIRUS; Google Scholar; IBSS; NICE; JSTOR; PubMed; Social Services Abstracts; ASSIA; PsychINFO; Social Care online; Cochrane Collaboration; Campbell Collaboration for publications between 2003-2013 using search terms "infant mental health" "foster care" "child abuse" "maltreatment." Tables of contents for the years 2009-2013 were also searched of the following journals: Child Abuse Review, Adoption and Fostering, Child Abuse and Neglect, Infant Mental Health Journal, British Journal of Social Work, Child and Family Social Work, Child and Adolescent Social Work. Of the 318 articles initially identified, 22 were deemed to meet inclusion criteria and a further 4 were identified from bibliographies of the included articles.

³ Sweet utilised five (unspecified) databases and 314 abstracts were collected studies appearing to be of relevance. After further examination of these abstracts 31 full text documents were retrieved for use in the review. Further documents were found through citations and reference lists; in total 44 studies were included and summarised in her literature review.

⁴ Many of the documents sent to us were in need of updating. For example, they referred to the Fostering of Children (Scotland) Regulations 1996 rather than the Looked after children Scotland Regulations 2009 which replaced them. Other documents were in draft form due to accommodating these changes. It may be this factor dissuaded some local authorities from sending us their documents.

varied from a single information pack for prospective foster parents to extensive documentation covering policy and practice guidelines and copies of pro forma used in practice (such as Placement Agreements). The sample was not representative and it is disappointing that no major city responded.

Two of the local authorities expressed an interest in being of further assistance and telephone interviews were conducted with senior managers of foster care at these authorities

3.3 Phase III – Interviews with Foster Carers

Seven foster carers were recruited from the two local authorities whose senior managers were interviewed at Phase II. Three foster carers being from one of these local authorities and four from the other. Between them, the seven foster carers had 165 years' experience of being foster carers. Two face-to-face group interviews (each with three foster carers) were conducted, as well as one individual face-to-face interview. All interviews were semi-structured, following the general pattern of a pre-determined interview schedule whilst allowing enough flexibility to pursue topics of relevance and interest as they arose.

Limitations of the data

While this study sheds light on some of the ways that local authorities in Scotland may strive to support foster carers to aid the recovery of children in their care who have been exposed to abuse and neglect, it cannot be assumed that the processes in place in the local authorities who took part in the research are representative of all local authorities in Scotland. Indeed, the documentation returned by the nine local authorities indicates that practices (such as the content of training) vary. The returning nine is a thin spread and no major city responded to our request. We acknowledge that managers are very busy, which may have precluded their involvement. The documentation itself was limited and did not include detail of pilot projects, the extent to which concurrency had been considered or developed, or whether there were local innovations in infant mental health. There is no requirement on local authorities to produce fostering policies and returned documents were on procedures rather than on service development or strategy. This is consistent with research in the 1990s, which identified the absence of set out fostering policy in local authorities (Triseliotis et al. 2000).

4. Looked after children under five years old

In 2013 there were 16,041 looked after children in Scotland, of whom 4,470 had become looked after in the year ending 31st July 2013 (SG, 2014).

Of these, 39% were young children under the age of 60 months (SG, 2014: Table 1:3). The numbers of children under the age of five who are who are becoming looked after has been steadily increasing. In 2003, there were 1,118 children under five who became looked after, compared to 1,737 in the year ending 31st July 2013. The increase is largely due to the increase in the number of infants under the age of a year that become looked after each year. This was 268 in 2003 but steadily rose to 700 in the most recently published social work statistics (SG, 2014: Table 1:3). Babies under the age of one year now account for 16% of all children starting to be looked after.

We do not know the precise number of children under 60 months who are in foster care in Scotland, because the Scottish Government statistics on looked after children does not break down the

numbers by both age and type of placement. Children who are defined as 'looked after' may remain living in their family home or may be placed with relatives (kinship care), rather than being placed with foster carers. However, we do know that, in 2013, for the second year running the total number of children looked after by foster carers'/prospective adopters was greater than those looked after at home (SG, 2014: pg 7).

Children may become looked after by a variety of means. They may be subject to a compulsory supervision order from the Children's Hearing System, or may be accommodated under s25 of the Children's Hearings (Scotland) Act 1995 or subject to a permanence order under s80 of the Children and Adoption Scotland Act 2007.

Of the 4,722 children of all ages who ceased to be looked after in the year ending July 2013, the majority were returned to their biological parent/s (68%).

Of the remaining children, 14% went to live with friends or other family. Six percent were in supported accommodation and 1% were living with former foster carers. Just 297 (6%) were adopted. (SG, 2014: Table 1:5).⁵

5. The mental health needs of young children who become looked after

Children who enter foster care have usually experienced multiple traumatic events (Oswald et al 2010 in Greeson et al 2011). These events include chronic neglect, exposure to domestic violence, and physical, sexual and emotional abuse as well as experience of a traumatic loss/ separation or bereavement (Greeson et al 2011 Table 1 pg 99; McAuley and Davis 2009:148). They have also often experienced more than one form of abuse (Wade et al, 2011).

The consequences for young children of exposure to these behaviours are diverse. Such children may be suffering from delay in reaching developmental milestones, be traumatised, have conduct (behavioural) disorders, and may have no secure attachment to any adult. Consequently foster carers with whom children are placed have to be prepared to deal sensitively with the behaviours of those children placed in their care.

However, not all children may show outward signs of distress. The Scottish Government, *Mental Health Strategy for Scotland 2012-2015* points out that:

An infant whose attachment becomes disorganised can experience high levels of stress and anxiety without necessarily showing an outward display of distress that would indicate to a caregiver that something is wrong (SG 2012:23).

In addition to existing stress, the process of being taken into care is also likely to be experienced as traumatic by the child (SG 2011: 138).

The consequences of (unresolved) childhood mental health problems can be far reaching and include impacts on education and employment, anti-social behaviour, substance misuse and relationship difficulties (Jenkins et al., 2008 in Parkinson, 2012:32).

⁵ A further 5% are recorded as having a destination 'other' and for 1% the destination is unknown.

It is important therefore that alternative care arrangements, including foster care, are formulated in a way that is sensitive to the mental health needs of the child, and the impact of being taken into care, as well as aiding them in their recovery.

5.1 Emotional and mental wellbeing of looked after children

In her review of mental health indicators for children in Scotland, Parkinson observes that:

The construct 'mental health problems' covers a continuum from symptoms that meet the criteria for clinical diagnosis of mental illness⁶ [...] to symptoms at a sub-clinical threshold, which interfere with emotional, cognitive or social function (Parkinson 2011:32).

It is noticeable when reviewing the research literature on the emotional and mental health issues of looked after children, that studies considering the types of issues children may face vary in the terminology they use as well as in how narrowly or broadly they consider a behaviour to be problematic. They also use different measurement tools. All of these may impact on the reported percentages of children who are identified as having a mental health need.

The broad range of diagnoses considered in the limited UK research literature on children in the care system include conduct (or behavioural) disorder (eg: Meltzer et al, 2003; Ford et al, 2007; Sempik et al, 2008; Richards et al 2006; Ford et al 2007); hyperactivity (eg: Meltzer et al, 2003); emotional disorders (eg: Meltzer et al, 2003; Richards et al 2006); as well as learning disabilities, post-traumatic stress disorder, obsessive compulsive disorder, autism and anxiety (Ford et al 2007).

The indication that a very young child may be experiencing any of these difficulties is usually deduced from the observed behaviour of the child. Studies into the mental health of young children may therefore rely heavily on the assessments of behaviour made by carers of the child or by social workers. Once a child is at school, the observations of teachers may augment these. Luke et al (2014) observe that:

particular care should be taken when considering carer-reported 'problems', which may in fact be a reflection of changes in their confidence rather than children's behaviour (Luke et al 2014:81).

Several tools exist for measuring care-givers assessments of different aspects of children's development - including social and emotional development. The Strengths and Difficulties Questionnaire (SDQ)(Goodman, 1997) is intended for use in respect of children aged from four years and the policy in England is that this should be completed for every child looked after for at least 12 months and aged between five to 16 years (DfE, 2013).⁷

⁶ Defined through recognised classifications such as the International Classification of Disease (ICD10) or the Diagnostic Statistical Manual Version IV (DSM IV). NOTE: The definition in the diagnostic and statistical manual (DSM-V) used by clinical psychologists requires that in addition to a recognisable pattern of behaviour (or symptoms) the behaviour should be associated with considerable distress and substantial interference with personal functioning.

⁷ A Questionnaire was returned in respect of 71.1% of looked after children in England fitting this criteria in the year ending 31st March, 2013.

In respect of children under this age, a version of the Child Behaviour Checklist (CBCL) (Achenbach, 1991) exists which may be used in respect of children from as young as 18 months of children (Achenbach & Roscorla, 2001).

However, Parkinson's review concluded that no suitable scale currently exists for assessing mental wellbeing in the early years (Parkinson 2012:30). For, although scales exist to assess 'related concepts, these have not been developed with mental health wellbeing in mind' (Parkinson 2012:30). Parkinson was particularly referring to the time period 24-30 months and at school entry.

Of particular interest is a recent study by Hardy et al (2013) which aimed to develop and implement a screening service that could identify the social and emotional needs of looked after children under the age of five years. The researchers on this project used the Greenspan Social and Emotional Growth Chart (SEGC; Greenspan, 2004) which is a brief questionnaire that assesses social and emotional development in children from birth to 42 months (in the Hardy et al study it was used for babies up to three months of age). The study also made use of the Ages and Stages Questionnaire: Social and Emotional (ASQ-SE; Squires et al, 2003), which assesses social and emotional development for children from three to 65 months. In addition the Parent Caregiver Involvement Scale (PCIS; Farran et al, 1986) was employed to assess caregivers' behaviour while interacting with the child over a 20 minute period. These tools were effective in providing insights into the interaction between the caregiver and child. That is, how the child responded to the care available to them as well as the responses of the caregiver to the child. Many of these responses were found to be deficient with particular evidence of low levels of vocalisation and reciprocity between babies and caregivers and this was linked to developmental delay. Common responses included that when the child hurt themselves, was tired or was in distress, the caregiver responded by believing the child was not in need or did not want their care; a reaction which may result in neglect.

Ongoing work in Glasgow with a large cohort of children has used the SDQ alongside the Sure Start Language Measure for the 30 month child assessment. The first paper from this study reports on the two year follow-up of this cohort, suggesting that the SDQ has worked very well in identifying children with psychiatric disorder, picking up all cases of ADHD and autism (Sim et al 2013).

5.2 Attachment disorders

It has been said by some that attachment theory should be the underpinning theoretical framework for all decisions concerning the care of looked after children (Furnivall et al, 2012:17). Given its importance, information supplementary to this section (detailing the types of attachment and how they arise) is given in Appendix A

Studies have found that children who have been subjected to severe rejection and abuse by their parents are more likely to find it difficult to develop a sense of trust in other adults (Sinclair et al, 2005; McAuley 2006 in McAuley and Davis 2009) and children coming into the care system are more likely to have weak or broken attachments (Howe & Fearnley 2003; Aldgate & Jones 2006 in McAuley and Davis 2009).

Once within the care system, when children have a secure placement (lasting over a year), their general health appears to improve (Meltzer et al 2003). However, the behaviour and emotional wellbeing of children who experience disrupted placements and multiple moves can deteriorate (Richards et al, 2006). Even children with disorganised attachment behaviours have been found to

be able to form new, secure, attachments with foster carers when appropriate support is put in place (Dozier and Lindhiem 2009). Research has shown that positive child behaviour is significantly related to caregiver commitment (Lindhiem and Dozier 2007). Specifically foster carers benefit from being supported to understand the often alienating behaviours of maltreated children, as well as how to override any of their own issues that may interfere with providing nurturing care.

This has implications for the formulation of care arrangements for looked after children. In order that the foster care arrangements for young children can best meet the emotional and mental health needs of very young children, it has to be formulated in such a way that the need for a secure attachment may be met as well as the need to be supported to recover from the trauma of abuse and neglect. Arguably, the latter may not be achieved without a focus on building the former, as section nine of this report (on foster carer experiences) draws out.

5.3 Reported prevalence of mental health issues in children under five years of age in the care system

It is perhaps not surprising, given a relative lack of tools for measuring mental wellbeing among children under the age of five years, that research into the mental health needs of looked after children has focused on children from the age of five years. This has consistently found that, compared to children in the general population, looked after children have higher rates of diagnosed mental illnesses (eg: Meltzer et al 2003; McAuley & Davis 2009).

One such UK study (Meltzer et al, 2003) considered the mental health of 1,039 children already in care in England, who were aged between five years up to the age of 17. The researchers assessed the presence of a mental health issues by use of structured interview with the carer of the child and reports that 45% of looked after children had a mental health issue compared with 10% in the population control group (Meltzer et al, 2003). The youngest age group analysed as part of this study were five-10 year olds and 36% of these children were found to have conduct disorders (compared to 5% of children in the population control group); while 11% were found to have emotional issues (compared to 3% in the control group).

By comparison, an earlier study from the United States (Greeson et al 2001) found that as many as 83% of the children in the care system (aged between 0-21 years, n=2,251) received at least one clinical diagnosis based on the data collected about them. However, study participants were recruited from centres working with children referred because of the need for trauma treatment. Also a broad range of measures was used in this study. These included interviews; UCLA Posttraumatic Stress Disorder-Reaction Index (Steinberg et al, 2004); Trauma History Profile; Child Behaviour Checklist (Achenbach & Rescorla, 2001) and clinical evaluations. No separate analysis was made of data on young children however.

A further UK study undertaken by Sempik et al (2008) reviewed the case files of children upon entry to care whom social workers recorded as having 'problems of concern to previous carers', and who were then referred for psychological assessment. The data was collected from 648 children aged 0-16 years. In respect of children aged under five years, they found that 18.9% of children entering the care system were considered to have emotional or behavioural problems. The figure was 14.7% for children under the age of three.

However, as the previously discussed study by Hardy et al (2012) found (see para 6:1), caregivers do not always recognise the problems very young children may have in communicating a need. A child may have difficulties but these may never be picked up by the caregiver, much less communicated to a social worker as a cause for concern. It was only through the participation of the caregivers in the study by Hardy that the full extent of the social and emotional needs of the 63 looked after children under the age of five years became apparent. The study found that 67% of the children (who were subject to the battery of assessment tools used by the researchers) had unmet socioemotional and mental health needs. The previous year, only 10% of looked after children under the age of five years within the same local authority had been recognised as needing an intervention. This is considerably higher than the 36% of looked after under fives with conduct disorders found by Meltzer et al (2003) and the 18.9% found by Sempik et al (2008) with emotional or behavioural problems.

Clearly, the breadth of behaviours considered by a study, the definition of disorder used, the methods for measuring the problem, and the number of different measures used, all impact on the reported prevalence of mental health issues among looked after children. Given that a significant percentage of looked after children have mental health needs foster care has to be formulated in such a way that those with these needs may be supported to recover.

6. The formulation of foster care in Scotland

The bulk of the law pertaining to fostering is to be found in Looked after Children (Scotland) Regulations 2009. The bulk of the law pertaining to adoption is contained within the Adoption and Children (Scotland) Act 2007.⁸ While the thirty-two local authorities in Scotland are responsible for the provision of foster care services in their area, this has to conform to the Looked after Children (Scotland) Regulations 2009 which set out duties for fostering panels and carer recruitment; assessment and approval; contact with birth parents and the Child's Plan as well as giving timescales for the planning and decision making process.⁹

The Scottish Government produced detailed Guidance on the 2009 Regulations (SG 2011) which provides a discussion of the policy aims underpinning the Regulations.

6.1 Fundamental principles to protect against unnecessary interference in family life

The European Convention for the protection of human rights and fundamental freedoms (ECHR) 1950, stipulates that: 'Everyone has the right to respect for his private and family life, his home and his correspondence.' The State may not interfere in the exercise of this right unless it is 'in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic wellbeing of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others' (Article 8 ECHR).

⁸ This Act also makes some minor amendments to previous legislation relevant to fostering.

⁹ Regulation 5 of the Looked after Children (Scotland) Regulations outlines the information that should be in the Child's Plan. These include: details of the supervision requirement; timescales for meeting of objectives and for reviews; how disagreements are to be dealt with; occurrences that would lead to a review hearing being arranged; any other plans relevant to the child, for example, child protection or a co-ordinated support plan for education. The Plan is a written agreement to which all involved can work (parents, teachers, social workers, foster carers etc.)

This ECHR is part of UK domestic law via the Human Rights Act 1998.

In addition, State Parties are to ensure that a child is not separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child (Article 9, United Nations Convention on the Rights of the Child, hereafter UNCRC). Such a determination may be necessary in a case involving abuse or neglect.

Indeed, in all actions concerning children, whether in a court of law, or by administrative authorities or social welfare institutions, the best interests of the child is the paramount consideration (Article 3:1 UNCRC).

When children are separated from their parents, then State Parties have to respect the right of the child to maintain personal relations and direct contact with both parents on a regular basis, unless this contact is contrary to the child's best interests (Article 9:3, UNCRC).

Consequently, when children are taken away from their parent/s and into the care system (subject to all the checks and balances of due process), it is necessary that this intervention in family life is at the minimum level necessary to secure the welfare of the child. If a child can be removed on a temporary basis only, while supports are put in place to assist the parent to regain the care of their child, then that is the option the local authority must pursue. If the child is looked after away from home, the local authority will almost always have to put arrangements for contact between the child and parent in place unless (or until) there is sufficient evidence that this is not in the best interests of the child.

This minimum intervention principle has a fundamental impact on the formulation of care arrangements for looked after children.

The Guidelines to the 2009 Regulations state:

Any intervention into family life may be experienced as an intrusion. In the regulations and guidance, interventions will range from compulsory supervision of a child or young person who remains at home through to the most significant intervention of the legal transfer of a child from one family to another through adoption. Clearly, the more significant and long lasting the intervention, the greater the onus to establish the necessity for that decision (SG 2011:12).

6.2 Direct contact and personal relations

The requirement on local authorities to take steps to promote contact and direct relations on a regular basis between the child and their parent/s is expressly stated at section 17(1)(c) of the Children (Scotland) Act 1995.

The Guidelines to the 2009 Regulations states:

The circumstances leading to the child being placed may have put strain on that relationship, so contact can be an opportunity to refocus on the good aspects. For other parents, contact may provide a space to work on less positive aspects of their relationship with their child or learn new skills and approaches to this. This requires support to all parties (SG 2011:40).

Increasingly foster parents are expected to facilitate this contact between a birth parent and a young child in their care. The Guidelines to the 2009 Regulations state that:

Foster homes may be appropriate venues for contact. Foster carers often play a role in facilitating contact and subsequent reunification (SG 2011:41).

Consequently:

The child's carers, whether kinship carers, foster carers or residential social workers, are a key part of the team ensuring effective use of contact; and this should be reflected in their preparation, approval, training and support (SG 2011: 40).

This expectation that foster carers will facilitate contact between a child and birth parent becomes particularly complex where foster carers are hoping to go on to adopt the child. This situation, concurrency planning, is permitted by the 2009 Regulations and discussed in this paper at section eight. The Guidelines to the 2009 Regulations state that when planning contact for a child who is placed with foster carers with a view to adoption, the Local Authority must consider:

How involved should the proposed adoptive family be given that this is an important time for them to build up trust with the child and demonstrate that they will be there for the child during possibly stressful times in their life? (SG 2011:160).

6.3 Promoting mental health for looked after children: Mental health assessments

In 2007 the Scottish Government set out an action plan to improve the life outcomes of looked after children (SG 2007).¹⁰ Action 15 stipulated that:

Each NHS Board will assess the physical, mental and emotional health needs of all looked after children and young people for whom they have responsibility and put in place appropriate measures which take account of these assessments (SG, 2007:43).

These assessments should take place within four weeks of the child becoming looked after. The Looked after Children (Scotland) Regulations 2009 stipulate that when children are placed with a carer as an emergency placement, the carer is to be provided with background information on the health and emotional development of that child in addition to other background information about the child.¹¹ This may enable the carer to better understand the behaviours the child displays and gauge how to respond to the child.

In 2012 the Scottish Government published its Mental Health Strategy for the years 2012-2015 in which it asserted that there is basic mental health training available to all those working with or caring for looked after children and young people (SG 2012:22), and includes the commitment to make this basic infant mental health training more widely available (Commitment 8). It also commits to work with a range of stakeholders to develop the current specialist Children and Adolescent

¹⁰ This led to the establishment of a "resource bank" of relevant information regarding looked after children accessible at <http://wecanandmustdobetter.org/>

¹¹ Looked after Children (Scotland) Regulations 2009. Reg 36(5).

Mental Health Services (CAMHS) scorecard 'to pick up all specialist mental health consultation and referral activity relating to looked after children' (Commitment 9). In pursuit of Commitment 9 the Scottish Government has established a Child and Mental Health Services Implementation and Monitoring Group, which has a sub-group focusing on looked after children.¹²

6.4 Promoting permanence

One of the underpinning concepts discussed within the 2009 Regulations is that of Permanence. To achieve permanence means to secure for the child a stable environment throughout their childhood (as opposed to multiple placements with different carers). This may be achieved through a range of placement options including kinship care, adoption, long term fostering or the return of a child to their birth parents.¹³

The Scottish Government Guidance on the 2009 Regulations state:

This concept of stability often called 'permanence' is an important framework for bringing together knowledge about child development, the development of attachment between children and adults, and the way in which this in turn leads to the creation of life long positive relationship. In practical terms, children require to be brought up in an environment which is safe, nurturing, predictable, consistently and continuously available. The daily experience of the child should be one that makes them feel that they are 'cared for' and cared about, as well as one in which physical needs are met. Such an environment supports children's emotional and psychological development by promoting self-esteem, resilience, hope and optimism for the future (SG 2011: 8).

At the time the Adoption and Children (Scotland) Act 2007 was passed which introduced 'Permanence orders', there was "recognition of the effect of prolonged uncertainty on children and their need for stability, predictability and the opportunity to form secure attachments" (SG 2011:13).¹⁴

The extent of this uncertainty has recently been highlighted by a study by the Scottish Children's Reporters Administration (Henderson, 2011), which found that out of 100 looked after children, only seven achieved permanence within two years of becoming looked after. This was despite the fact that 44% of the children had been identified as being at risk either at or before birth. The Looked after Children (Scotland) Regulations 2009 includes guidelines and timescales for different parts of the planning and decision-making processes.¹⁵

¹² Details of the Group's work (including minutes of meetings and proposed future action) can be accessed here: <http://www.scotland.gov.uk/Topics/Health/Services/Mental-Health/Strategy/Child-Adolescent-Services>

¹³ However the review of the Local Authority documents undertaken for this study, revealed a tendency to use the term as a synonym for securing permanent care *outwith* the birth family.

¹⁴ A permanence order is a new type of court order introduced by the Adoption and Children (Scotland) Act 2007 which regulates the exercise of parental responsibilities and parental rights in respect of children who cannot reside with their parents but where contact or shared exercise of parental responsibilities and parental rights is or may be appropriate. A permanence order may remove some or all parental responsibilities and parental rights and grant them to other persons specified in the order.

¹⁵ For example Regulation 45(2) stipulates that when a child is becomes looked after, there must be a review of the case within 6 weeks.

The Guidelines to the 2009 Regulations states:

There is clear and robust worldwide research which shows that effective planning for infants requires urgency: a birth parent's progress with overcoming drug or alcohol addiction, for example, needs to be achieved within a timescale that meets the developmental needs of a young child. For children under the age of two, this implies making firm decisions about permanence and the suitability of birth parents within a matter months (SG 2011: 12).

One potential means of avoiding delays to permanence for looked after children is to simultaneously start putting into place arrangements for the permanent placement of a child outwith the family of origin, whilst still working with the birth parent to try and effect changes that would allow the child to return home. This is known as parallel or twin-track planning.¹⁶

Alternatively, concurrency planning is an option, that is, placing a child with a carer who is dual registered as both a foster carer and a prospective adoptive parent. This means that the foster carer may go on to adopt the child if sufficient evidence is available that reunification with the family of origin (or placement with kinship carers) are not viable options in all the circumstances of the case. The legal hurdles to be overcome in order to place a child with a foster carer with a view to adoption by that person are substantial however. This is particularly the case in Scotland because the agreement of both the Children's Hearing System (CHS) and a court of law are required.

However, because concurrent planning has such potential to benefit children by offering stability and the possibility of establishing and maintaining a secure attachment with a carer, without the harmful impact of disrupted and multiple placements, the use of concurrent planning as well as the barriers to its use are discussed more fully later in this report (section eight).

Whether children are placed with a carer with a view to their long term care remaining with that person, or as an emergency or short term placement, there are many ways in which foster carers can be supported to help children placed with them to recover from the effects of abuse and/or neglect. It is these that are considered in the next section.

7. How local authorities may equip foster carers to support recovery and improve the mental health of infants in their care

This section of the report discusses findings from a review of the local authority documents returned by nine local authorities in Scotland, as well as from the interviews with local authority managers.

Key factors identified which may equip foster carers to meet the mental health needs of infants in their care are: appropriate training and matching of the carer to the child; ongoing support for foster carers; and inclusion of the foster carers views when making arrangements for the looked after child. This section considers each of these in turn.

¹⁶ The Guidelines to the 2009 Regulations do not use the term 'parallel' planning but do mention 'twin track' planning twice, without providing a definition. The Guidelines simply state: "Planning should therefore take account of various possible options, at/or returning home, or away from home. Models of "twin tracking" should be considered" (SG 2011:24). They also state that Local Authorities need to be clear of the meaning of the term (SG 2011:188).

7.1 Training

In December 2013, the final report of the Looked After Children Strategic Implementation Group recommended that:

...the Scottish Government should commission a National Learning and Development Framework for Foster Care, underwritten by new National Care Standards (Fostering) or Regulations.

It was further proposed that the training framework, which would apply to all fostering agencies in Scotland, should be accredited and progress through the stages should provide carers with the opportunity to obtain qualifications (Looked After Children Strategic Implementation Group, 2013).

This part of the report presents information on the existing training provided within four of the nine local authorities who returned documentation, as the documents returned by the other five local authority did not include any information on the content of any training provided by them.

Where there were training and competency documents provided, there was commitment and expectation that foster carers should be skilled and knowledgeable and have an opportunity for personal development. The general process is to give foster carers the opportunity to achieve a standard for registration and then progress from that through three or four levels. This means that they are able to care for children with more difficulties and challenges. Levels of payment were aligned with the skill and qualifications; this was the preferred route rather than associating it directly with a child.

The local authorities set out opportunities for, and expectations that foster carers would take up training on a regular basis. This commenced prior to and is a requirement for registration. Training in core skills could continue for some time afterwards. There was the expectation that foster carers needed to have some understanding of child abuse and neglect and the impact it has for children. Across the documents there was indication of foster care training on child abuse and neglect and its impact on children and young people; child development and attachment. Neonatal abstinence was also an element in training programmes, with at least one area indicating this was in response to requests from foster carers. These are generally individual elements in diverse training programmes that include aspects such as first aid and attending looked after reviews and children's hearings.

According to training programmes there could be one day courses at an introductory level, although there were instances of more in depth courses even for core skills. The Fostering Network Skills for Fostering is used in the preparation for fostering and has a section on attachment. Materials available from the British Association for Adoption and Fostering (BAAF) may also be used. Where the local authority runs courses through their Early Years Services they may also be able to provide places for carers on that, as well as sometimes providing places for carers on the training provided for Child Protection Committees. One manager flagged up that in response to Scottish Government encouragement to look at strategic commissioning of training, some authorities now operate a training collaborative and are able to provide courses through that means.

One local authority had prioritised developing knowledge and understanding of attachment for all children, family and foster care staff and foster carers responsible for vulnerable children on the basis it would be beneficial for all ages. This has involved a period of expert input in training in previous years that was refreshed annually subsequently. This drew on attachment theory and ways to get attachment right. This was believed to have valuable short and longer term benefits, for example LAC reviews always check where the child's attachment is at and what can be done to improve. Most authorities provided standard and required training and were responsive to foster carers' needs or issues emerging.

There were examples of developed competency schemes for foster carers that set out the requirements they were expected to meet within two years of approval and how to progress. Integral in this were a review scheme and payment levels. These could be fairly detailed in setting out the carer expectations and particularly here we highlight instances of the relevant aspects for foster care of young children. The first level included basic child care. Secondly is the ability to work appropriately with children according to their age and developmental stage. Here the expectation is that a carer can recognise when a child is demonstrating the effect of child abuse and neglect, including when they are distressed or withdrawn. The foster carer may not be confident in dealing with this but is expected to seek help and improve their knowledge. Level one has foster care staff working with the family, in a non-judgemental way to support contact and with relevant public services i.e. education and social work. The level two competences include all those at level one, and the expectation is to be proactive in a number of ways. This includes being able to help the child develop social behaviour that may specifically be to address attachment issues they may have and development difficulties due to trauma and loss. These carers are expected to be able to respond to deal with child abuse and neglect and record and assess the child's development in order to share with the social worker. The main collaborative working here is with other professionals in provision of therapeutic provision. By stage three the carer is experienced and skilled and expected to lead on therapeutic work with the children and their families, in line and in partnership with relevant professionals. They should understand and cope with disturbed behaviour. They should have knowledge of relevant law and legal processes. Interestingly for these carers there is an expectation that they will work with the family to prevent the child coming into care. This can be provision of care in the child's home, being a guide and role model to parents. Integral to all levels is the requirement to seek and take part in training as part of continual development.

The support given to foster carers was viewed as integral to placement success and this seemed to be an allocated social worker that would visit at least once a month. This is more straightforward where there is a stable team. What is beneficial in one interview area was the responsiveness to training needs; being open and challenged by foster carers; having the knowledge of what is effective e.g. modelling of behaviour for parents.

7.2 Matching

During the assessment stage local authorities work out with foster carers, which would be the best age group for them based on their skills, experience, personal circumstances and preference. The British Association for Adoption and Fostering (BAAF) forms E and F are utilised by local authorities in this planning, prompting analysis of the collected information and helping to link this to BAAF standards. One foster care manager expressly stated that they would not approve a foster carer for the range 0-16 years but only for particular age groups, with 0-five years being one such age group.

Both local authority managers commented on the increasing numbers of babies coming into foster care (aged under 18 months), with increasing numbers coming into care at birth, because of parental drug and alcohol abuse. Because of this they said they needed to ensure they foster carers for this age group are equipped (mostly through training) to deal with drug withdrawal symptoms and fractious babies. Foster carers of this age group are also likely to have to be more actively involved in facilitating contact between the child and birth families [see section on supporting contact at 9.5].

While local authorities try to match the carer and child as far as possible, the nature of emergency placements means this is not always possible:

The fostering team have a good grasp of the carers' skills and who would be good matches. Sometimes, just because of the resource situation you will be having a conversation with them and saying, 'actually while X would be perfect for this child it is not going to work because they don't have a space or there is another child that they have in placement [...]' so there are some placements that maybe push the carer a bit (local authority manager).

Because of this resource pressure, some foster carers indicated that while they were registered for the care of children in the age range zero to four years, sometimes an older child was placed with them. One recently having been given the emergency care of an 11 years old.

7.3 Support

From the review of local authority documents and interview data, it was possible to detect the following types of support given to foster carers, which may help them support the mental health needs of a child in their care.

- Provision of information on the background of the child;
- Health assessment of the child (and sharing of key information with the foster carer);
- Access to professionals able to provide advice when the foster carer has concerns about the child or feels unable to cope;
- Ongoing training (discussed in the previous section) particularly where this is in response to identified need or requests by the foster carer for training on specific issues.

7.3.1 Provision of information about the child's background and needs

When a child is accommodated, the carer will be given background information about the child and the Child's Care Plan.¹⁷ There will also be a Placement Agreement.¹⁸ This Placement Agreement is to include information on the 'the child's state of health and need for health care and surveillance and the name of the child's doctor during the foster placement.'¹⁹ It also includes any arrangements for delegation of parental responsibility for consent to the medical or dental examination or treatment of the child.²⁰ When the placement is an 'emergency' placement (one lasting up to three days) the 2009 Regulations stipulate that:

¹⁷ This is a requirement under the Looked after Children (Scotland) Regulations 2009. Reg 5

¹⁸ This is a requirement under the Looked after Children (Scotland) Regulations 2009. Reg 27 and Schedule 4.

¹⁹ Looked after Children (Scotland) Regulations 2009 . Schedule 4, S 1 (d).

²⁰ Looked after Children (Scotland) Regulations 2009. Schedule 4, s3.

they must provide the person with whom the child is placed with information about the child's background, health and emotional development.²¹

Foster carers were clear on the value of background information, stating that it:

Help[s] you to understand the child. If you know what has happened in the child's past or with the parents and whether they have been in care before (foster carer).

However, in emergency situations, foster carers will not always immediately have the full information about a child. One local authority manager said that they often have to accommodate children that they know little about and pass on what information they can.

While one foster carer observed:

In an emergency, it [information] can be scant [the social worker] will do her best to get information and will post it out or drop it off or if they have been with a previous carer you could be put in touch with them so you can get information on what they like to eat, their sleeping and if the child has any allergies (foster carer).

Fundamental information such as this clearly is vital to the early interactions between the child and their new carer, particularly with such young (and possibly pre-verbal) children.

7.3.2 Health assessment

Initial information about the child can be augmented by the health assessment that is undertaken by a paediatrician during the first four weeks of the child becoming accommodated (previously discussed in 7.3). This covers questions such as is the child well and enjoying life? and are there any significant behavioural problems? as well as questions on social and emotional development. Both the foster carer and the birth parent will usually be at this health assessment however, according to the foster carers taking part in the present study, the doctor questions the birth parent rather than the foster carer.²² The full findings go to the child's social worker. Where key findings of relevance are shared with the foster carer this may aid that person in the care of the child.

While foster carers described attending this mandatory health assessment with infants in their care, they did not always seem sure whether it had covered the mental health needs of the infants with one suggesting 'It is more about the physical side of things' and another stating 'well they ask questions but I would not say it looked at their mental health.'

In addition to this mandatory health assessment local authorities may provide supplementary assessments if the foster carer expresses concern about the child's behaviour.

²¹ Looked after Children (Scotland) Regulations. Reg 36(5).

²² As many of these birth parents have abused or neglected their child there are arguably issues around the reliability of their accounts.

One local authority manager participating in the study explained that they may also provide a full mental health assessment of the child if the foster carers concerns are such that this appears warranted (such as excessive tantrums or withdrawn behaviour).

Notably, these health assessments are in addition to the nine and 30 month health checks by a health visitor, which are undertaken on all infants in Scotland.

7.3.3 Access to professionals

Because caring for a child who has been subjected to abuse or neglect can be particularly challenging, foster carers benefit from support in the form of access to trained professionals.

One local authority Foster Carer Handbook reports that:

Some studies have shown that the best treatment for a child in such circumstances [challenging behaviour] is ongoing specialist advice and the availability of consultation to the carer who then feels more able and confident in understanding and responding to the child.

This handbook gave details of the local CAMHS service and how that service may be accessed via an appointment with a GP after first discussing the concern with the child's social worker.

The foster carers interviewed in this study provided clear descriptions of the course of action they would take if the behaviour of a child in their care was a cause for concern:

Normally you would work through it with advice from the health visitor or if you are really starting to feel it you would maybe phone the social worker [...] but usually because the children have been known by the health visitor since birth she has a great deal of knowledge and she is the one to turn to if you need anything (foster carer).

However, another foster carer who had only started fostering within the last 18 months described how they had felt they had been left alone to 'paddle their own canoe' when it came to trying to understand the disturbed behaviour of the child in one of their earliest placements.

There was evidence that in some local authorities provision is made for foster carers to be visited by their allocated social worker on a regular basis, usually once a month for support and advice. Some local authorities also facilitate a foster carer support group whereby foster carers are able to meet, share experiences and provide support for each other.

7.3.4 Inclusion of foster carers

Foster carers said they appreciated being kept informed - particularly timeously – when changes were made (such as in respect of contact times with the birth family). They also valued the inclusion of their full and accurate responses to questioning by a social worker, in reports written by that social worker.

"I have had health visitors phone me the day before a meeting and been asked relevant questions on the child and then at the meeting the following day, the report they give is almost word perfect to what you have said over the telephone." (foster carer).

Those who took part in this research also described in positive terms opportunities to be on consultative committees or working groups on issues affecting looked after children.

However, a recurrent theme within the interviews with foster carers was a concern that although they were the individuals with the day to day care of the child and a keen awareness of the child's behaviours, they did not always feel their views were accurately presented, or even adequately gauged, when decisions were made regarding their future care of the child:

...at that meeting there must have been twelve or thirteen professionals around that table and it occurred to me that the two people that knew that child the most, were the two who did not really get a say and that was myself and mum [of the child] (foster carer).

One local authority response intended to address this is ensuring the social worker who represents the foster carer is present at any Looked After Child (LAC) reviews or at any Child Protection Case Conferences:

...[foster carers] rights can be abused by the child's social worker, because they think, 'Right, you'll do this and you can do this.' And before the foster carer knows it, they're roped into all sorts, which has got a big impact on their own family life (Foster Care Manager).

However, foster carers – who were generally positive about this support – pointed out that their social worker was not always able to accompany them due to having to attend to something else.

A sense of being excluded was expressed most keenly in respect of placement of a child for adoption or to be returned to the birth family. In respect of placement of a child for adoption:

When we got to the placement meeting to discuss the adoption of the child I was asked to leave before things were discussed. Who is the one person who knows most about this child? And he is being asked to leave (foster carer).

But by the time you [foster carer] get to the stage when you actually meet the family and everything, it's well, well down the line. And that's when it's always awkward, because although you'll say, 'I'm not particularly happy about this, I've got reservations about them for this child', by that stage it's a bit late to stop the thing rolling on (foster carer).

This perceived exclusion needs to be viewed in the light of the expectation of foster carers that they will contribute at meetings and the significant role foster carers can play in advocating for the child that is in their care. One example that came out of the interviews was set within the context of the Children's Hearings System. The foster carer of a four year old with disabilities and significant developmental delay described how she went to the Hearing and was seated next to the boy's grandparent who was denying the child's delayed development:

I was like butterflies in my stomach and I like had to explain how he can just manage a shape sorter and I managed to say everything I had been doing with him and the levels he was at. When I was going through my training [to be a foster carer] there was worry that I would not be able to speak at meetings and I was pleased and proud of myself cos I was able to say 'no I am speaking for this wee boy who cannae' (foster carer).

Clearly foster carers fulfil several vital roles in respect of the children placed in their care. Local area authorities are able to support them in ways that go beyond careful thought given to the placement of the child, the provision of information on the child and the provision of training. Rather acknowledging and including the experiences of the foster carer in caring for the child, may help inform the permanence planning for that child.

For some children, the LA may decide the best placement would be with a foster carer who may go on to adopt that child – concurrency planning.

8. Use of concurrency planning to meet the mental health needs of infants

Concurrency planning involves placing a child with a carer who is dual registered as both a foster carer and an adoptive carer in the context that there is a high risk the child may not be able to return to their families. So doing means that if the decision not to return the child to the birth parent(s) is taken, the child may remain with the same carer permanently and not suffer the disruption of severance from an adult to whom they are securely attached (the foster carer) as that adult may become the child's adoptive parent.

This differs from the more typical situation - where a child placed with foster carers may be assessed as suitable for adoption by someone else (not their foster carer) when it becomes apparent they cannot return home.

Concurrency planning also differs from the broader terms 'twin tracking' or 'parallel planning' which refer more broadly to the exploration and progression of different options simultaneously for a looked after child.

A report published by the Centre for excellence for looked after children in Scotland (CELCIS) states that:

Concurrency planning seeks to minimise the impact of disordered attachment for children likely to result from being placed with multiple care givers (Wassell 2012: 3).

This section of the report reviews the extent to which concurrency planning is promoted within the Looked after Children Regulations 2009 and within the local authorities who took part in this research project.

8.1 Concurrency planning and the Looked after Children Regulations 2009

There is limited reference to concurrency within Scottish Government policy documents. The 2009 Regulations do not use any of the terms 'concurrency planning', 'twin track planning' 'parallel planning' nor 'fostering with a view to adoption.'

However the Scottish Government Guidance on the 2009 Regulations do mention the possibility of concurrency planning:

The legislation permits the situation where a child moves to live with a family who can offer adoption before the question of the parents' consent is resolved and this is also reflected in the terminology of the regulations (SG 2011, 160).

The Guidelines also refer to circumstances in which concurrency planning may be appropriate:

The principles and tools developed in concurrent planning projects in other jurisdictions are useful in identifying the small number of infants where active exploration of permanence options away from the birth parents should be explored alongside potential rehabilitation (SG 2011: 12).

The specific cohort of children coming into care that concurrency is especially relevant for are:

- Young children (under two in particular)
- The child's relationship with the birth family is non-existent, tenuous, damaging or dangerous.
- The return home is unlikely to be safe or feasible.
- The child has the potential to become a full member of another family (as he or she does not see him or herself as belonging to their birth family) (Adapted from SG 2011: pgs 11-12).

One of the Local Authority managers pointed out the significance of the fact that concurrency is only appropriate for very young children in circumstances that indicate it is very unlikely they will return home:

If it is the strict concurrency model, the number of children who would fit into that are tiny. In the [more than five] years I have been here there are maybe three babies that would have fitted that model (Local Authority Manager).

She went on to suggest that such small numbers make this difficult to justify in terms of resource allocation to develop such services. However, this was a small local authority with few looked after children under age five. It might not be a valid justification in larger areas. CELCIS, in their paper on concurrency planning, point out that:

The current process of caring for children away from home is expensive. Not just at the point of frontline service provision when a child is received into care, but also in terms of the lifelong negative consequences that poor attachment and instability have on children (Wassell 2012: 5, citing Social Work Inspection Agency, 2006).

The economic and welfare benefits of concurrency require more research attention.

8.2 Concurrency planning in practice

None of the documents sent to the research team from the nine local authorities used the term 'concurrency planning' to mean placement with a potential adopter acting in a fostering capacity.

Local Authority managers were aware of the potential for confusion over the terminology:

People do not understand 'concurrency', 'dual planning' and all the other terms that are used. We recently agreed we would not use these terms but just say what is being proposed (Local Authority Manager).

Who knows what any of these words mean? It would be a different thing to every single person. We don't have a concurrency project [...] (Local Authority Manager).

Local authorities pointed out the confusion in meanings for parents as well, where they assume the model means the child will automatically be taken from them. Parents receive intensive support with the hope of reunification and in fact the emotional burden is on the potential adopters. Indeed, the emotional burden on adults is possibly the main barrier to the model. It is a deeply entrenched idea that potential adopters should not have to cope with the emotional burden of legal uncertainty. It is NSPCC's view however that infants should not have to bear the brunt of the emotional burden through placement moves and a lack of foster care commitment (in terms of attachment to adult care givers). Prior evidence exists that the right support can mitigate adult anxieties if children's interests are prioritised (Monck et al 2003; Wigfall et al 2006).

It could be argued that concurrency is an initiative in the process of the adoption of children rather than in fostering practice because the legal and practical implications of fostering and those of adoption differ vastly.

Adoptive parents acquire full parental rights and responsibilities in respect of the child, the child becomes a permanent member of their family and is owed a duty of financial support by them and will inherit from them.

Although long term foster parents who have a child placed with them under a Permanence Order from a court of law may have some limited rights granted to them in respect of the child for as long as the child is placed with them, the local authority retains the rights to regulate the residence of the child as well as the responsibility to provide guidance to the child.²³ The foster carer is not recognised in law as being the parent of the child.

While the foster carers who were interviewed as part of this project were clearly committed to their role as foster carers of the children placed with them (whether temporary or longer term care of children), they were aware that the child could be removed from them at any point by the local authority. Indeed the Foster Care Agreements they are obligated to sign includes agreement to relinquish the child at the request of the Local Authority. By contrast, prospective adoptive parents

²³ Adoption and Children (Scotland) Act, Section 81.

are actively seeking to become the permanent parent of a child (or children). Necessarily therefore, concurrent planning places an emotional burden on a prospective adopter who must contemplate the possibility of a child being returned to their birth parent. This ambiguity of expectations on the foster carer is a real tension. Foster carers spoke of having to distance themselves on the one hand, but seen as not doing the job properly if they were not upset when children moved. They referred to 'Moving On' training preparation for emotions when child and adults part. If this tension is at the centre of the role, how can care be provided which optimises the child's best outcomes?

One manager observed that while there had been some successes with concurrency in England but was of the view that this may reflect the different legal system:

It has been done with varying degrees of success in England, mostly lead by Coram who are a voluntary organisation based in London and they have sorted the legal stuff out but they just have the courts to deal with. We have the children's Hearing System as well (Local Authority Manager).²⁴

Although the legal processes required to effect concurrency planning are complex, the benefits of avoiding a disrupted placement are significant for the child involved. It is suggested here therefore that further research into how the concurrency model may be effectively implemented in practice in Scotland is needed. Whilst the legal complexities may be overstated, the perception that the legal system is too complex is a barrier in itself.

9. The experience of foster carers in meeting the emotional and mental health needs of children.

This section of the report presents the views of foster carers on what they perceive the mental health needs of children in their care to be and how they seek to meet those needs. Key among these are the need to build attachment, to model positive behaviour and to stimulate the child's mental and physical development.

Foster carers also describe ways in which their actions may impact on the future care of the child, as they are required to support contact between the infant and child and to maintain accurate recording of concerns they have that may impact on future decisions regarding the child.

9.1 Building attachment

Through providing warm, consistent and reliable care to the baby, infant, toddler or pre-schooler that may be placed in their care, potentially foster carer can facilitate the formation of an attachment between the child and themselves which will benefit the child whilst in their care and act as a template for the sort of relationship that is possible for the child throughout their life. All of those who took part were from local authority which emphasise the importance of a secure attachment between an infant child and carer in the training given to foster carers and this was reflected in the importance the foster carers attached to building a bond with the infant.

²⁴ See Laws, Wilson and Rebindrakumar (2012) *Concurrent planning study; interim report*. London: Thomas Coram Research Institute.

One of the things they talk about more than anything else is nurturing and bonding with the child and you can't do anything else if you are going to look after this child. To me, people who just distance themselves and look after their physical needs but don't do that emotional bit are not doing the job properly (foster carer).

Whilst striving to build this attachment, foster carers described key ways in which they go about providing the care that may enable a child to recover from the effects of abuse and neglect. Core among these were:

- modelling positive behaviour;
- stimulating development (both physical and mental);
- managing challenging behaviour.

These are considered here in turn.

9.2 Modelling positive behaviour

The value of modelling positive behaviour was keenly understood by foster carers in interview. They saw their role as:

...being as good a family for them [the child] at that time is so important, because it's not – I mean, that's one thing I found quite reassuring that [trainer] was saying the last time, is even if you're just modelling good behaviour for that time, it's better than it not (foster carer).

[We] teach them the kind of things that you would teach your own children to do. You know, how to sit and eat properly at a table. Routine. Getting them into some kind of routine. They have probably never had routine in their life before some of these children. Teach them bedtime. Read to them. All the things I do with my grandchildren when they come. All the things they have maybe missed out on (foster carer).

[Our role is] to be there and let them know you are going to look after them and you are going to be good to them and to teach them boundaries and let them know that they can't have everything, just the way you would your own (foster carer).

We are trying to make good memories as all the memories are bad (foster carer).

9.3 Stimulating development

Children placed into foster care may have delayed development of their motor, communication and social skills due to the abuse and/or neglect to which they have been exposed. Physical neglect can also impact on their physical growth.

Several of the foster carers gave examples of how they had aided the development of the children they had cared for over the years and in so doing illustrated the devoted nature of the care that foster carers may give a child.

A wee baby we got, he was tiny due to alcohol. We had to take him through to the specialist doctor in [city] and she was always measuring him and weighing him and I had to see the dietician cos he was tiny. And feeding him butter and the gold top cream. Everything had to be high fat for him to try and build him up. He left us when he was about one and a half when he went to [kinship care] (foster carer).

Although a child's parents must still consent to anything other than routine medical treatment for children in foster care, nonetheless at the commencement of a placement the child's social worker gives the carer a medical consent form signed by the parent(s) to facilitate effective care of the child.

As well as practical, physical care to aid development, foster carers gave examples of ways in which they aided the mental development of children, enabling them to engage with others.

He [toddler] would sit and you would talk to him and he would just completely ignore you but now if I say his name he will look and if you say 'clap handies,' he will turn and he will clap his hands. He will engage. When he is in his car seat it is all 'Baa Baa Black sheep' he loves his singing, loves that tune. And a lot of the time it is like putting on a light switch in their brain and slowly they will come to realise that this is what they can get from an adult (foster carer).

9.4 Managing challenging behaviour

Foster carers gave examples of the sorts of behaviours they had observed children in their care display.

I had a wee boy who was one when he came to us and in the first year he just screamed constantly. I could nae leave him or even turn my back to him. That was alcohol with the mum and I think it was just pure neglect. [...] Thankfully he settled down and made attachments and his speech and everything was great by the time he left us (foster carer).

It was like he had had a great trauma. He shut down a lot. He would not come to you for his emotional needs like a cuddle or something. He would sit and stare at you and burst into tears and I would have to get up and say to him 'come on, do you want a cuddle' and lift him. He was a lovely little boy but it was just as if something had gone.... like a trauma in his life which he was too young to tell us about.[...] it was just that he froze all the time and he did not play properly, he just sat with a frozen expression on his face but something must have been going on in his head because all of a sudden you would see the tears come and he would burst out crying (foster carer).

Some also provided examples of how they addressed challenging behaviour:

When [toddler] first came to us, he was banging his head. He would not let you say 'no' to him and he avoided all eye contact. So I just sat with him over the last few months, played 'peek-a-bo' with him, sang nursery rhymes with him. I spoke to the health visitor and she advised to ignore the head banging and he would go out into the hall and do it and you would ignore him so he would go [elsewhere] to do it, you know wanting attention, but he does nae do it now (foster carer).

However, despite all the training and support services, one interviewee who had only recently become a foster carer described feeling perplexed and alone with their concerns:

He [three year old boy] was emotionally in a very difficult place. He was feral. He would scratch. He would make noises like a cat. He would go into the most horrendous tantrums. He was very stressed and yet there was no support for us at that time. What do we do? How do we cope with this boy who is very clearly distressed? [...] we felt on our own to try and work out how we could soothe him and heal him. We were left to trawl through the textbooks (foster carer).

Given the extreme nature of some of the behaviours children who have been abused and/or neglected may display, and the emergency nature of many of the placements (where information about the child may be minimal) foster carers would benefit from access to 24 hour support. One local authority foster carer manager observed in interview that, if given a 'magic wand,' this would be a definite priority. It may also be the case that the core training for registration to become a foster carer could more consistently cover how to approach some of the more common behavioural consequences of abuse and neglect.

9.5 Supporting permanence arrangements

As discussed earlier in this report, the term 'permanence' refers to a stable long-term placement for a child, whether that is with foster carers, through adoption or through a return to the birth parent/s. Because of the minimum intervention principle when a child is placed in foster care, social workers may sometimes think that the baby will not go home, however until or unless they accumulate sufficient evidence in support of this, they have to make a full attempt at rehabilitation of the child to the birth parent/s. Increasingly foster carers play a pivotal role in this.

9.5.1 Supporting contact with birth parent/s

As increasing numbers of very young babies coming into care, foster carers have a greater part to play in the contact between families and the child in their care than if they were caring for a teenager where the family relationship had broken down. While it may be the case that the foster carer just has to have the baby ready to be taken by a contact worker to the venue where they are to have contact with a birth parent, in some instances the foster carer may be expected to facilitate contact between the child and the birth parent within the foster carers own home – particularly in the context that reducing resources have resulted in a significant reduction in contact workers.²⁵

One local authority manager of foster carers observed of carers of infants:

They have to be able to deal with lots of contact with families, uncertain contact with families, work with families, build relationships with families [...] they also have to be able to work within quite tight timescales in terms of rehabilitation and to be able to deal with permanency (local authority manager).

²⁵ One local authority foster care manager reported a 60% reduction from when she first worked at that local authority.

However, establishing and maintaining the relationships can be challenging:

A relationship with the parents is really, really helpful. Because the children are torn, a lot are torn between the two. But it doesn't matter how good a foster carer you are, if the parent doesn't like social work, then they're not going to like the foster carer (Local Authority Manager).

The foster carers were aware of the potential antagonism towards them from birth parents and volunteered ways in which they tried to be diplomatic.

The parents like their children to be dressed in the clothes that they've provided, and it's just wee touches like that. They're going to contact, put the wee dress on that they've bought for them, but the wee coat on that they've bought for them, and let them see them (foster carer).

I learnt very early on, was that you do not get their hair cut, because that is a really, really sensitive issue (foster carer).

Through sensitive interactions with birth parents, foster carers may be able to influence the future care that that parent may provide to the child when the child is returned to the parent. In this way also, they may also be able to support the development of an attachment between the parent and child.

9.5.2 Informing permanence decisions

Foster carers are uniquely placed to observe the child in their care on a 24 hour a day basis.

Local Authority Handbooks for foster carers list record keeping as an essential task for foster carers. For example, one Handbook states:

Carers will be supplied annually with a separate diary in which they should record events such as appointments, Child's Plan Meetings, training dates, etc. Carers must maintain a record of each placement. Separate records must be kept for each child and entries must be dated and signed by the Carer. Records must be stored in a secure place and passed back to the child's Social Worker at the end of the placement for inclusion in the child's file

As well as recording details of meetings, the diary should record concerns the foster carer has and the date on which they notified a social worker of these. The full nature or extent of the abuse or neglect a child has been exposed to may not be known at the time the child is removed into care and local authority documents stress the importance of foster carers accurately recording their observations and what children have said when those words indicate a cause for concern:

If children display sexualised or unusual behaviour, carers should record their observations and share these with the child's social worker and the link worker. It is possible that there may be a pattern to the behaviour that indicates that the child has been abused.

and

Children may also use particular words or phrases for things which have little meaning on their own but which, when put together with other behaviours, are an indication that abuse may have occurred. It is essential that what is recorded is written exactly as the child says it. Your record could be important evidence in any subsequent investigations or court proceedings, and you may be cited as a witness.

Foster carers are also encouraged to record any observations of the child's behaviour before, during and after contact with birth parents. Instructions are clear they should record only what they observe.

The records that foster carers keep inform the decisions of those responsible for formulating the future care of the child. In this way, this aspect of the foster carers' role can impact on the future mental health of the child currently in their care.

As all of the foster carers interviewed were foster carers only (rather than being dual registered as potential adopters and foster carers), none of them had experience of the concurrency process.

10. Conclusion and recommendations

This report has presented a number of pertinent findings into the extent to which foster care may provide a basis for meeting the emotional and mental health needs of young children. The focus has been on the ordinary care provided by foster carers, rather than add-on interventions that may be offered to foster carers to help them support children in their care.

Against the background that increasing numbers of children under the age of 60 months are entering the care system in Scotland and burgeoning numbers of looked after children are being placed with foster carers, the necessity that foster carers are equipped to recognise and respond to the mental health needs of this cohort is crucial.

The literature review on the mental health needs of children under the age of 60 months found that children within the care system are more likely to have a mental health issue than children in the general population. However estimates of the prevalence of mental health issues vary depending on how broadly a mental health issue is defined, how it is measured, how many different measurements are used and how the population studied is accessed. There are also fewer assessment tools available which may be used to detect a mental health vulnerability in a child under the age of 60 months and those that are available generally rely on caregiver assessments of the child's need. These may not always be reliable. Further, the recent review undertaken for the Scottish Government on establishing a core set of sustainable mental health indicators, concluded that no suitable scale currently exists for assessing 'mental wellbeing' in the early years (Parkinson 2012).

While health assessments are mandatory for children entering the care system, it is not clear from the literature reviewed for this report, nor from the interviews with local authority managers and foster carers, the extent to which these assessments consider the mental health needs of such young children. We recommend that research into the practice of the initial health screening given to children in Scotland who become looked after should be undertaken. This should review the

screening measures used, the reliability of carer assessments in this context, and the extent and type of treatment offered following the identification of an unmet mental health need. Factors impacting on the uptake of the treatment should also be reviewed.

There is evidence that the local authorities who took part in this research aspire to equip foster carers to address the mental health needs of the infants in their care. This is done through the provision of on-going training, efforts to match the child to an appropriate carer and the provision of information about the child to the carer. However the content of the training materials vary across local authority. Furthermore, the emergency nature of many placements may mean ideal matching of the foster carer to the child is not always possible at the time the child is taken into care. It also may not be possible to provide the background information at the same time that that child placed with the carer.

Support for foster carers may also come in the form of access to professionals when specific concerns arise, particularly individuals able to give advice on how to respond to challenging behaviours. Foster carers would like access to this advice to be available 24 hours a day. One foster care manager stated this is the one thing she would ask for if she were given a 'magic wand.' It is suggested here that a study into existing telephone support for foster carers and the feasibility of such a service being established (perhaps nationally) would be very useful.

The foster carers who took part in this study spoke of the ways in which they strove to support the young children in their care to overcome the often traumatic impact of abuse and neglect. They spoke of establishing routines, of ensuring they interacted with the child to stimulate development and of providing warmth and care. They also spoke of attending hospital appointments with the child so that the improvement in the child's physical development could be supported. It was through this ordinary care that they addressed the child's needs. We recommend further research on the use of add-on interventions aimed at supporting looked after children's unmet mental health needs in Scotland, where these exist.

Finally, this study found mixed views on concurrency planning in the local authorities, which took part in the study. It is known, however, that there are local authorities in Scotland that have embraced concurrency planning robustly. It is recommended that further research into how the concurrency model may be facilitated so that very young children can remain with the same caregiver, rather than experience the effects of ruptured attachment, should be undertaken.

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APPENDIX A: Attachment Types

Attachment is an area of infant development, initially developed by Bowlby (1951), which has been expanded, advanced and refined through research and practice with maltreated children and those not in the care of their biological families. There are four types of attachment behaviour: secure; avoidant; ambivalent and disorganised. A securely attached child looks for, and receives, comfort from their main carer:

In the optimal situation babies experience care giving from one or two adults which is predominantly reliable, sensitive and attuned to their individual temperament and needs. These children develop secure attachments to their caregivers which enable them to express distress and accept comfort easily and which also allow them to explore their world with an inner certainty that their caregiver will be available to them if needed (Furnivall 2012:10).

Secure attachment in children is linked to developing belief that they can influence their environment and this gives them a basis for building autonomy, confidence and adaptation particularly with regard to emotional regulation (Dozier et al., 2009; Fish & Chapman, 2004; Lloyd & Barth, 2011; Furnivall 2011; van den Dries, Juffer, van Ijzendoorn, & Bakermans-Kranenburg, 2009).

The three remaining behaviours are manifestations of **insecure** attachment.

Avoidant attachment behaviour is displayed when an infant seems unconcerned when separated from their carer. This type of attachment develops when the infant learns to suppress their negative emotions because their care-giver responds negatively (either in an aggressive manner or by withdrawing from them). It is important to note that despite the suppression of emotions these infants have been found to be experiencing 'intense anxiety' when their physiological responses are measured (Furnivall 2012:10).

Ambivalent (or 'anxious resistant') attachment is shown when an infant, who becomes distressed when separated from a carer, then withdraws from, or resists, attempts to provide comfort from the carer on return. This is believed to be because the infant may be able to prolong the availability of the caregiver by resisting being comforted.

Disorganised attachment behaviour is when an infant is unable to develop an organised way of reacting to a caregiver as that caregiver is also frightening to them. While their fear makes them want proximity that caregiver is also the source of the fear.

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